State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete and mail original and one copy to:

STATE COMPENSATION INSURANCE FUND, CLAIMS MANAGEMENT SERVICE

P O BOX 255127, SACRAMENTO, CA 95865-5127

ALSO SEND ONE COPY TO: CALIFORNIA EMERGENCY MANAGEMENT AGENCY - ATTENTION ANITA CHANT
3650 SCHRIEVER AVENUE MATHER CA 95655

(Claims Management Service is a division of State Compensation Insurance Fund)

OSHA Case No.

DR

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health

COUNCIL

1. LOCAL ACCREDITED DISASTER COUNCIL

1a Policy Number N/A

2 MAILING ADDRESS (Number and Street City Zip)

2a Phone Number

3 LOCATION if different from Mailing Address (Number Street City and Zip)

3a Location Code N/A

4 NATURE OF BUSINESS; e.g Painting contractor wholesale grocer sawmill hotel etc

DISASTER SERVICES

5. STATE UNEMPLOYMENT INSURANCE ACCT NO N/A

6 TYPE OF EMPLOYER

☐ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL DIST. ☒ OTHER GOVERNMENT - SPECIFY **DISASTER COUNCIL**

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)

8 TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M.

9 TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M.

10 IF EMPLOYEE DIED DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO

12 DATE LAST WORKED (mm/dd/yy)

13 DATE RETURNED TO WORK (mm/dd/yy)

14 IF STILL OFF WORK CHECK THIS BOX ☐

15 PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO

16 SALARY BEING CONTINUED? ☐ YES ☐ NO

17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)

19 SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available e.g Second degree burns on right arm tendonitis on left elbow lead poisoning

19a BODY PART AFFECTED

20 LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address)

20a ZIP

20b COUNTY

21 ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO

22 DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED e.g Shipping department machine shop

23 OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO

24 EQUIPMENT MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED e.g Acetylene welding torch farm tractor scaffold

25 SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED e.g Welding seams of metal forms loading boxes onto truck

26. HOW INJURY/ILLNESS OCCURRED DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS e.g Worker stepped back to inspect work and slipped on scrap material As he fell he brushed against fresh weld and burned right hand USE SEPARATE SHEET IF NECESSARY

27 NAME AND ADDRESS OF PHYSICIAN (Number Street City Zip)

27a. Phone Number

28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes then NAME AND ADDRESS OF HOSPITAL (Number Street City Zip)

28a Phone Number

29 Employee treated in Emergency Room? ☐ YES ☐ NO

ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

DISASTER WORKER

30. EMPLOYEE NAME

31 SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City, Zip)

33a. PHONE NUMBER

34 SEX ☐ MALE ☐ FEMALE

35 OCCUPATION (Regular job title NO initials, abbreviations or numbers NOT DSW Volunteer Job)

36 OCCUPATION (REGULAR JOB TITLE NOT SPECIFIC ACTIVITY AT TIME OF INJURY NOT DSW VOLUNTEER JOB / CLASSIFICATION)

37 WAS WORKER REGISTERED WITH A LOCAL ACCREDITED DISASTER COUNCIL?
IF SO WHICH

38. DID INJURY ARISE OUT OF ACTIVITIES AS A DISASTER SERVICE WORKER?

Completed By (type or print)

Signature & Title

Please do not use this Column
Case Number
Ownership
Industry
Occupation
Sex
Age
Daily hours
Days per Week
Weekly Hours
Weekly Wage
County
Nature of Injury
Part of body
Source
Event
Secondary Source
Extent of Injury
Date (mm/dd/yy)

*Confidential information may be disclosed only to the employee, former employee or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

SCIF e3267 (REV 05-09)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT